Letter of Medical Need

FBMC
proven benefit solutions
P.O. Box 1800, Tallahassee, FL 32302-1800

Why would I need to submit a Letter of Medical Need?

When you enrolled in your Employer's Medical Expense Flexible Spending Account (FSA) plan, you agreed to the following:

- I will only use my FSA to pay for IRS-qualified expenses, permitted under my Employer's plan, incurred by me, my spouse and my IRS-eligible dependents
- I will exhaust all other sources of reimbursement, including those provided under my employer's plan(s), before seeking reimbursement from my FSA
- I will not seek reimbursement through any additional source and
- I will collect and maintain sufficient documentation to validate the foregoing.

FBMC, along with your Employer, has developed these instructions to assist you in complying with this agreement by explaining how and when to use a Letter of Medical Need.

What expenses are eligible?

Eligible expenses include amounts for the diagnosis, cure, mitigation, treatment or prevention of disease or for the purpose of affecting any structure or function of the body, and are confined strictly to those incurred primarily for the prevention or alleviation of a physical or mental defect or illness. Please refer to your Employer's current plan year Flexible Benefits Plan Reference Guide for additional information on expenses eligible through your Employer's plan.

How do I seek reimbursement?

In order for incurred expenses to be reimbursed from your Medical Expense FSA, you must follow these instructions. Only the cost of medical care and services permitted under both IRS Code § 213 and your Employer's Medical Expense FSA plan are reimbursable. If these expenses include those services, procedures, medicines or items that can be provided for both a medical purpose and a cosmetic, personal, living and/or family purpose, as well as those involving some capital expenditures, additional substantiation must be submitted with your claim.

What is a capital expenditure?

A capital expenditure is an item that has a useful life that extends beyond the end of the taxable year, such as an elevator, bathtub railings, etc. A capital expenditure may be reimbursed if its primary purpose is:

- to provide medical care for you as a participant, your spouse or tax dependent for an existing medical condition and
- properly substantiated as medically necessary by showing that it would not be medically necessary "but for" an existing medical condition.

A separate Capital Expenditure Worksheet is required when you submit a request for reimbursement of a capital expenditure. Refer also to the information in your Employer's current plan year Flexible Benefits Plan Reference Guide and on your FSA Reimbursement Request Form. For more assistance or to obtain a sample form, visit FBMC's Web site at **www.fbmc-benefits.com**, contact Fringe Benefits Management Company (FBMC) Customer Service by e-mail at **webcustomerservice@fbmc-benefits.com** or call 1-800-342-8017, 7 a.m. to 10 p.m., Monday through Friday.

Note: If improper reimbursement of ineligible Medical Expense FSA expenses has been made, the corrective procedures approved by the IRS and permitted under your Employer's Medical Expense FSA plan will be followed.

When do I need to submit a Letter of Medical Need?

A Letter of Medical Need must be submitted with your FSA Reimbursement Request if the expense:

- can be provided for both a medical purpose and a cosmetic, personal, living and/or family purpose and/or
- is a capital expenditure, as previously defined.

For recurring expenses that continue for more than one plan year, such as orthodontia, you must submit a new Letter of Medical Need at the start of each plan year you intend to request reimbursement for the expenses.

Letter of Medical Need Instructions:

Please **print** all information requested on the reverse of these instructions, except signatures, to ensure proper handling. At the top of the Letter of Medical Need, you must include:

- the FSA participant's name
- the FSA participant's Social Security number
- the name of the FSA participant's employer
- the patient's name and
- the patient's relationship to the Medical Expense FSA participant.

The health care provider responsible for the patient's diagnosis and treatment of the condition specified, such as a doctor, dentist or acupuncturist, must complete the remainder of your Letter of Medical Need before you submit it with your FSA Reimbursement Request. This health care professional must be sufficiently qualified to diagnose and treat the condition for which the reimbursement is being requested. For more information, clarification or questions, contact FBMC Customer Service by e-mail at **webcustomerservice@fbmc-benefits.com**, or call 1-800-342-8017.

Note: If the reimbursement request is for treatment not normally associated with the condition indicated by your health care professional in the Letter of Medical Need, additional substantiation may be required.

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PLEASE PRINT ALL REQUESTED INFORMATION, EXCEPT SIGNATURES, TO ENSURE PROPER HANDLING. SEE REVERSE FOR ADDITIONAL INSTRUCTIONS.

Participant Name: _____ **Participant's Social Security Number:** _____

Participant's Employer: _____

Patient Name: _____ **Relationship to Participant:** _____

THIS SECTION MUST BE COMPLETED BY THE PATIENT'S HEALTH CARE PROVIDER RESPONSIBLE FOR THE DIAGNOSIS AND TREATMENT OF THE CONDITION SPECIFIED BELOW.

I am currently treating _____
Patient's Name

for _____.
Medical Condition

I certify that the prescribed treatment, service, procedure, equipment, supply and/or capital expenditure, listed below, is medically necessary to treat the specified medical condition (diagnosis), and is not intended to merely preserve or promote my patient's general health or well-being, satisfy nutritional needs nor primarily serve a cosmetic, personal, living and/or family purpose.

Medical treatment, service, procedure, equipment, supply and/or capital expenditure:

_____

_____

_____

Treating Health Care Provider Signature: _____ Date Signed: _____

Printed Health Care Provider Name: _____

Health Care Provider Address: _____

_____

_____

Health Care Provider Phone Number: _____

Health Care Provider Fax Number: _____